

Exhibit 19

PART B

<p>⑨ SECONDARY SCHOOL/ COLLEGE UNIVERSITY ATTENDED:</p>	<p>List any secondary school, college, or university attended.</p>		<p>Dates Attended</p> <p>From To</p> <p>MO. YR. MO. YR.</p>	<p>No. School Years</p>											
	<p>Name <u>University of Benin, Nigeria</u></p> <p>City/State/Country <u>UNIVERSITY OF BENIN, NIGERIA</u></p>		<p><u>1081</u> <u>1087</u></p>	<p><u>6yrs</u></p>											
	<p>Name <u>KINGS COLLEGE LAGOS NIGERIA</u></p> <p>City/State/Country <u>LAGOS NIGERIA</u></p>		<p><u>0674</u> <u>0679</u></p>	<p><u>5yrs</u></p>											
<p>⑩ MEDICAL DEGREE AND</p>	<p>Title of Medical Degree <u>MBBS.</u> Date Conferred:/Expected: <u>MO. 10 YR. 87</u></p> <p><small>* If the degree has been conferred, a photocopy must be sent to ECFMG. See Medical Education Credentials section of the ECFMG Information Booklet.</small></p>														
<p>⑩.1 MEDICAL SCHOOL:</p>	<p>Name of Medical School from which you graduated or expect to graduate. LIST EXACT NAME AND ADDRESS.</p> <p><u>UNIVERSITY OF BENIN</u></p> <p>City/State/Country <u>EDO STATE NIGERIA</u></p>		<p>Dates Attended</p> <p>From To</p> <p>MO. YR. MO. YR.</p> <p><u>1081</u> <u>1087</u></p>	<p>No. of Years Attended</p> <p><u>6</u></p>											
<p>⑩.2 OTHER MEDICAL SCHOOLS ATTENDED:</p>	<p>Name _____</p> <p>City/State/Country _____</p> <p>Name _____</p> <p>City/State/Country _____</p> <p>Name _____</p> <p>City/State/Country _____</p>														
<p>⑩.2 CLINICAL CLERKSHIPS:</p>	<p>Clinical Discipline</p>	<p>Hospital/Clinic</p>	<p>Location (exact address)</p>	<p>Supervising Physician</p>	<p>Dates of Clerkship</p>										
	<p><i>See Part D of this application for entering clinical clerkships.</i></p>														
<p>⑪ MEDICAL LICENSURE: Present or Future</p>	<p>Date you received (or expect to receive) an unrestricted license or certificate of full registration to practice medicine:</p> <p><u>MO. 01 YR. 89</u> Country or state in which you are licensed: <u>NIGERIA</u></p> <p><small>* If the license has been issued, a photocopy must be sent to ECFMG. See Medical Education Credentials section of the ECFMG Information Booklet.</small></p>														
<p>⑫ HOSPITAL TRAINING: Residency or fellowship</p>	<p>Hospitals</p>		<p>Position(s)</p>	<p>Dates</p>											
<p>⑬ EMPLOYMENT: Present employment only</p>	<p>Institution/Company</p>		<p>Position</p>	<p>Dates</p>											
	<p>Name: _____</p> <p>Street: _____</p> <p>City/State/Country: _____</p>														
<p>⑭ BIRTHDATE/ BIRTHPLACE:</p>	<p>Day <u>01</u> Month <u>01</u> Year <u>59</u> Location: <u>BENIN CITY EDO STATE</u></p> <p style="text-align: right;"><small>City, Province, Country</small></p>														
<p>⑮ GENDER:</p>	<p>Please check one: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female</p>		<p>⑮ NATIVE LANGUAGE: <u>EDO</u></p>												
<p>⑰ CITIZENSHIP:</p>	<p>(Complete all three)</p> <p>A. AT BIRTH <u>NIGERIAN</u> USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____</p> <p>B. UPON ENTERING MEDICAL SCHOOL USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____</p> <p>C. NOW <u>NIGERIAN</u> USA <input type="checkbox"/> or Other <input type="checkbox"/> (Specify) _____</p>														
<p>⑱ OTHER EXAMINATION HISTORY AND APPLICANT NUMBERS:</p>	<p>Check below the organizations to which you may have applied previously; enter the date of the most recent examination that was administered to you and the identification number that was assigned to you by that organization.</p> <table border="0" style="width:100%;"> <tr> <td style="width:30%;"> <p>ORGANIZATION</p> <p><input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS</p> </td> <td style="width:20%;"> <p>DATE OF MOST RECENT EXAMINATION TAKEN</p> <p>MO. YR. <u>1</u> <u>9</u></p> </td> <td style="width:20%;"> <p>APPLICANT IDENTIFICATION NUMBER</p> <p>NBME Parts I/II <u> </u></p> </td> <td style="width:20%;"> <p>USMLE Steps 1/2 <u> </u></p> </td> <td style="width:10%;"></td> </tr> <tr> <td> <p><input type="checkbox"/> STATE LICENSING AUTHORITY IN THE UNITED STATES</p> </td> <td> <p>MO. YR. <u>1</u> <u>9</u></p> </td> <td> <p>FLEX <u> </u></p> </td> <td> <p>FEDERATION IDENTIFICATION NUMBER (FIN) <u> </u></p> </td> <td></td> </tr> </table>					<p>ORGANIZATION</p> <p><input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS</p>	<p>DATE OF MOST RECENT EXAMINATION TAKEN</p> <p>MO. YR. <u>1</u> <u>9</u></p>	<p>APPLICANT IDENTIFICATION NUMBER</p> <p>NBME Parts I/II <u> </u></p>	<p>USMLE Steps 1/2 <u> </u></p>		<p><input type="checkbox"/> STATE LICENSING AUTHORITY IN THE UNITED STATES</p>	<p>MO. YR. <u>1</u> <u>9</u></p>	<p>FLEX <u> </u></p>	<p>FEDERATION IDENTIFICATION NUMBER (FIN) <u> </u></p>	
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PART C

ECFMG-000644

☐ STATE LICENSING AUTHORITY
IN THE UNITED STATES

MO. 1 9 YR.

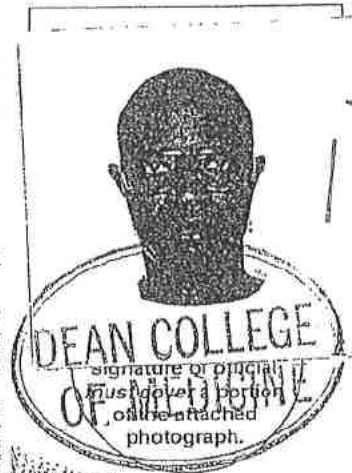
PART C

Students and graduates must sign the application in the presence of their Medical School Dean, Medical School Vice Dean, or Medical School Registrar. (See A below.)

If a graduate cannot sign the application form in the presence of a medical school official noted above, he/she must sign the application form in the presence of a Consular Official, First Class Magistrate or Notary Public (See B below) and must explain in writing why the application form could not be signed in the presence of a medical school official. (See B.1 below.)

Application forms are to be mailed to ECFMG from the office of the official or notary who witnesses the applicant's signature.

All information on the application form is subject to verification and acceptance by the Educational Commission for Foreign Medical Graduates.



19 CERTIFICATION BY APPLICANT

I hereby certify that the information in this application is true and accurate to the best of my knowledge and that the photographs enclosed are recent photographs of me.

I also certify and acknowledge that I have received the current edition (that which pertains to the administration for which I am registering) of the combined Information Booklet on ECFMG Certification and Application for USMLE Step 1 and Step 2 examinations and USMLE Bulletin of Information, am aware of the contents of both sections and meet the eligibility requirements set therein.

I understand that (1) falsification of this application, or (2) the submission of any falsified educational documents to ECFMG, or (3) the submission of any falsified ECFMG documents to other agencies, or (4) the giving or receiving of aid in the examination as evidenced either by observation at the time of the examination or by statistical analysis of my answers and those of one or more other participants in that examination, or engaging in other conduct that subverts or attempts to subvert the examination process, may be sufficient cause for ECFMG to bar me from the examination, to terminate my participation in the examination, to withhold and/or invalidate the results of my examination, to withhold a certificate, to revoke a certificate, or to take other appropriate action. (See Information Booklet for additional details concerning Validity of Scores and Irregular Behavior.)

I understand that the ECFMG certificate and any and all copies thereof remain the property of ECFMG and must be returned to ECFMG if ECFMG determines that the holder of the Certificate was not eligible to receive it or that it was otherwise issued in error.

I hereby authorize the Educational Commission for Foreign Medical Graduates to transmit any information contained in this application, or information that may otherwise become available to ECFMG, to any federal, state or local governmental department or agency, to any hospital or to any other organization or individual who, in the judgment of ECFMG, has a legitimate interest in such information.

Signature of Applicant X

Johanna Akoda

Date

8/29/96

A. I hereby certify that the photograph, signature, and information entered on Section 10 of this form accurately apply to the individual named above.

X Signature of Medical School Official (In Latin Characters)

Official Title

Date

Institution

B. I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn to before me by the applicant on this _____ day of _____, 19 _____.

X Signature of Consular Official, First Class Magistrate, Notary Public (In Latin Characters)

Official Title

B.1 Explain in the space below why the application could not be signed in the presence of your medical school dean, vice dean or registrar. Any explanation must be acceptable to ECFMG and must be provided each time you submit an application to ECFMG.

RECEIVED

AUG 30 1996

ECFMG

19 CERTIFICATION BY MEDICAL SCHOOL OFFICIAL

OR

CERTIFICATION OF IDENTIFICATION WITH EXPLANATION
(Pertains to graduates only)

FOR OFFICE USE ONLY	
FORM	DATE
S.A.	
I.D.	
338	
339	
325	
R.A. - M 9/11/96	

20 Have you ever been denied licensure or authority to practice medicine by any medical licensing or registering authority, or has any such license or authority to practice medicine ever been suspended or revoked?

If the answer to this question is "Yes," please explain fully on a separate sheet of paper, giving details such as date, location, charge, and action taken; and provide any supporting documents.

☐ Yes

☒ No

21 Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information; however, the processing of your application will not be affected if you choose to leave item 21 blank.

Select the one which best describes your racial/ethnic background.

1 ☐ American Indian/
Alaskan Native

2 ☐ Asian
Pacific Islander

3 ☐ Hispanic

4 ☒ Black (not of
Hispanic Origin)

5 ☐ White (not of
Hispanic Origin)

6 ☐ Other

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